WORKERS’ COMPENSATION

Notice to Employees:

State law requires your employer to provide workers’ compensation insurance for its employees. Workers’ compensation insurance provides benefits to employees who are injured at work.

If you are injured at work, NOTIFY YOUR EMPLOYER AT ONCE. You may lose your right to receive benefits unless your employer is notified within 90 days of your injury. Your claim is also subject to a two year statute of limitations. Worker advocates are available at the Workers’ Compensation Board to help injured workers.

If you have any questions about your rights, please contact one of the regional offices.

Aviso a los Trabajadores:

La ley del estado de Maine requiere que su empresario proporcione el seguro de compensaciones para el trabajador a todos los trabajadores. El seguro de compensaciones para el trabajador proporciona beneficios a los trabajadores accidentados en el trabajo.

En caso de sufrir accidente o daño laboral, NOTIFÍQUELO INMEDIATAMENTE A SU EMPRESARIO. Podría perder el derecho a recibir compensación a menos que su empresario sea notificado de este accidente o daño en el plazo de 90 días. Así mismo esta reclamación debe hacer referencia a un
D’après les lois de l’État du Maine, votre employeur est tenu de souscrire à une assurance indemnisant ses employés victimes d’un accident du travail.

Si vous êtes victime d’un accident du travail, PREVENZE VOTRE EMPLOYEUR IMMÉDIATEMENT. Passé un délai de 90 jours, vous risquez de perdre vos droits à l’indemnisation. Au-delà de deux ans, votre déclaration n’est plus recevable. Pour aider les vic-

accidente o daño que no haya ocurrido hace más de dos años. Los defensores del trabajador están disponibles para proporcionar ayuda a los trabajadores accidentados en el Consejo de Administración de Compensaciones para el Trabajador (Workers’ Compensation Board).

En caso de tener cualquiera pregunta sobre sus derechos, favor de dirigirse a una de las oficinas regionales de compensaciones para el trabajador.
EMPLOYER'S FIRST REPORT OF OCCUPATIONAL INJURY OR DISEASE

REASON FOR REPORT (check all that apply)

1a. WCB FILE NUMBER (if known):
1b. OSHA 300 CASE NUMBER (if applicable):

2a. LOST TIME - ONE OR MORE DAYS
2b. WAS EMPLOYEE PAID FOR 1/2 DAY OR MORE ON DAY OF INJURY? □ YES □ NO
3. LOST EARNINGS BUT NO LOST TIME
4. MEDICAL/HEALTH CARE
5. FATALITY DATE OF DEATH: MM DD YYYY
6a. OCCUPATIONAL DISEASE
6b. DATE OF LAST EXPOSURE: MM DD YYYY
6c. DATE OF DIAGNOSIS AS OCCUPATIONALLY RELATED: MM DD YYYY
7. FATALITY DATE OF DEATH
7b. DATE OF CORRECTION: MM DD YYYY
7c. DATE CORRECTION SENT TO WCB: MM DD YYYY

EMPLOYER

9. STATE EMPLOYER UNEMPLOYMENT INSURANCE ACCOUNT NUMBER (UIAN):
10. EMPLOYER NAME:
11. STREET/P.O. BOX MAILING ADDRESS:
12. CITY:
13. STATE:
14. ZIP:
15. TELEPHONE NUMBER:

16. PRIMARY BUSINESS PERFORMED BY EMPLOYER WHERE INJURY OCCURRED:
17. EMPLOYER LOCATION IF DIFFERENT FROM MAILING ADDRESS:
18. DID INJURY OR EXPOSURE OCCUR ON EMPLOYER'S PREMISES? □ YES □ NO IF NO, THEN GIVE NAME AND PHYSICAL ADDRESS OF THE EMPLOYER WHERE THE EMPLOYEE WAS INJURED OR EXPOSED:

(check one) □ INSURER
□ THIRD PARTY ADMINISTRATOR (TPA)
□ SELF-ADMINISTERED EMPLOYER

19. INSURANCE/TPA COMPANY NAME:
20. POLICY NUMBER:
21. INSURER FILE NUMBER:
22. STREET/P.O. BOX MAILING ADDRESS:
23. CITY:
24. STATE:
25. ZIP:
26. TELEPHONE NUMBER:

EMPLOYEE

27. LAST NAME:
28. FIRST NAME:
29. MI:
30. TELEPHONE NUMBER:
31. SOCIAL SECURITY NUMBER:
32. GENDER: □ MALE □ FEMALE
33. STREET/P.O. BOX MAILING ADDRESS:
34. CITY:
35. STATE:
36. ZIP:
37. DATE OF BIRTH: MM DD YYYY
38. OCCUPATION/JOB TITLE:
39. DATE OF HIRE: MM DD YYYY
40. WEEKLY WAGE AT TIME OF INJURY: $
41. DOES EMPLOYEE WORK FOR ANOTHER EMPLOYER? □ YES □ NO IF YES, GIVE NAME AND ADDRESS:

CLAIM INFORMATION

42. DATE OF INJURY OR ILLNESS: MM DD YYYY
43. DATE OF INCAPACITY: MM DD YYYY
44. TIME EMPLOYEE BEGAN WORK (e.g. 7:30 a.m.):
45. DATE EMPLOYER NOTIFIED INSURER/TPA: MM DD YYYY
46. TIME OF INJURY (e.g. 1:10 p.m.):
47. HAS EMPLOYEE RETURNED TO WORK? □ YES □ NO IF YES, GIVE DATE: MM DD YYYY
48. SPECIFIC INJURY OR ILLNESS (e.g. second degree burn or toxic hepatitis):
49. BODY PART(S) AFFECTED (e.g. lower right forearm):
50. ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN THE EVENT OCCURRED (e.g. acetylene torch, metal plate):
51. SPECIFY ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE EVENT OCCURRED (e.g. cutting metal plate for flooring):
52. HOW INJURY OR ILLNESS OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED OR MADE THE EMPLOYEE ILL. (e.g. worker stepped back to inspect work and stepped on some scrap metal. As worker fell, worker brushed against hot metal):

WAS ACTIVITY PART OF NORMAL JOB DUTIES? □ YES □ NO
53. HOSPITALIZED OVERNIGHT AS INPATIENT? □ YES □ NO
54. WAS THE EMPLOYEE TREATED IN AN EMERGENCY ROOM? □ YES □ NO
55. HEALTH CARE PROVIDER NAME:
56. MAILING ADDRESS:
57. TELEPHONE NUMBER:

PREPARER INFORMATION

58. PREPARER NAME AND TITLE (TYPE OR PRINT):
59. TELEPHONE NUMBER: MM DD YYYY
60. DATE SENT TO WCB: MM DD YYYY

WBC-1 (1/02) The State of Maine does not discriminate on the basis of disability in admission to, access to, or operation of its programs, services or activities. This material can be made available in alternate formats by contacting your Department ADA Coordinator.

DISTRIBUTION: COPY (1) MAINE WORKERS' COMPENSATION BOARD, 27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027. (2) EMPLOYEE. (3) INSURER. (4) EMPLOYER

WC 7808d (1-02) UNIFORM INFORMATION SERVICES, INC.